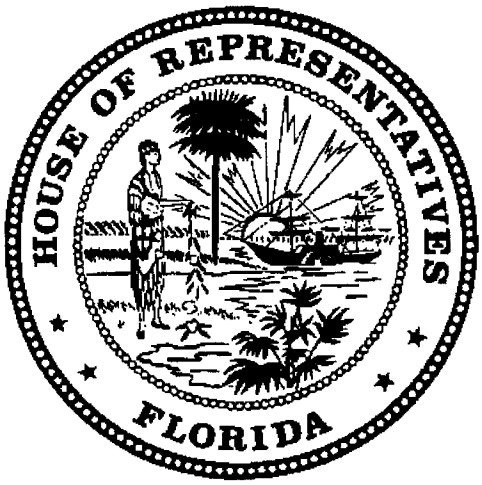

Health Care General Committee

Wednesday, January 25, 2006
9:30 AM – 12:00 PM
306 HOB

COMMITTEE MEETING PACKET

Allan G. Bense
Speaker

Gayle B. Harrell
Chair

AGENDA

Health Care General Committee
January 25, 2006
9:30 a.m. – 12:00 p.m.
306 HOB

I. Call to order/Roll Call

II. Opening Remarks

III. Consideration of the following bill:

- HB 393 - - Lead Poisoning Prevention Screening and Education Act by Joyner

IV. Workshop on the following:

- HB 89 - - Emergency Management by Harrell

V. Presentation by the Florida Hospital Association on the Crisis in Emergency Care Report

VI. Presentation by the Florida College of Emergency Physicians on Florida Report Card on Emergency Care

VII. Closing Remarks and Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 393 Lead Poisoning Prevention Screening and Education Act
SPONSOR(S): Joyner
TIED BILLS: **IDEN./SIM. BILLS:** SB 642

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee		Ciccone	Brown-Barrios
2) Health Care Appropriations Committee			
3) Governmental Operations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

House Bill 393 creates the "Lead Poisoning Prevention Screening and Education Act."

The bill establishes a public information initiative for the purpose of communicating to the public the significance of lead poisoning prevention. The bill expands the Department of Health's role as the entity responsible for this initiative.

The bill establishes a screening program within the Department of Health to systematically screen children less than six years of age within certain categories and requires that the Department of Health maintain comprehensive screening records. The bill also requires the Department of Health to disclose cases or probable cases of lead poisoning to the affected individual, his or her parent or legal guardian if the individual is a minor, and to the secretary of the Department of Health.

The fiscal impact of this bill is estimated by the Department of Health at $798,802. The provisions of this act will take effect upon the Department of Health receiving a federal lead poisoning prevention grant of $1m or greater.

The bill provides an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provides limited government

This bill expands the Department of Health's health education and awareness activities with input from private industry.

Empower families

As a result of receiving certain public health advisements, this bill empowers families to choose housing or living accommodations based on accurate health-risk information.

B. EFFECT OF PROPOSED CHANGES:

Background

Due to potentially harmful effects, lead-based paints were banned from use in housing in 1978. Children are at particular risk for lead exposure due to their regular hand-to-mouth activity during daily play where lead-based paint is peeling or flaking. The dust from this deteriorating paint is easily ingested and is a significant source of exposure.

According to the Department of Health, lead poisoning became a reportable disease in 1992. Since then, more than 7,100 children in Florida have been identified with a confirmed case of lead poisoning. Lead poisoning can affect nearly every system in the body, and because lead poisoning often occurs with no obvious symptoms, it frequently goes unrecognized. Lead poisoning can cause learning disabilities, behavioral problems, and at very high levels, seizures, coma, and even death.

Program Background

The Childhood Lead Poisoning Prevention Program (CLPPP) was established in 1992 with a grant from the Centers for Disease Control and Prevention (CDC). The CLPPP currently operates within the Department of Health (DOH), Bureau of Community Environmental Health.

Since 1992, the state CLPPP has received up to $1 million dollars annually from the CDC and distributes the majority of these funds to the Miami-Date, Pinellas, and Duval county health departments who continue to operate comprehensive childhood lead programs. However, due to anticipated federal grant reductions, the state may not receive the amount of money received in the past. A small amount of funding is also distributed to Broward, Hillsborough, Orange, Palm Beach and Polk counties. Like Miami-Date, Pinellas and Duval, these five counties also have a number of older housing units and a large population of at-risk children. In total, CDC funding supports fourteen full-time and seven-part time DOH staff.

The United States Department of Health and Human Services' Health People 2010 strategy for improving the Nation's health includes eliminating elevated blood lead levels in young children ages one to five years old. The CDC required all state and local CLPPP's to develop a strategic plan to meet this objective. To develop this plan, the CDC encouraged states to convene an advisory committee to assist in the development and implementation of the jurisdictional wide plan to eliminate lead poisoning. The Florida CLPPP convened an Advisory Committee in late 2003. The program worked with the committee to develop a statewide strategic plan to meet the elimination goal. The plan is available on the CDC website.[1]

[1] www.cdc.gov

Screening Background

Florida developed a statewide Screening Guideline (updated in 2001) with grant monies from the CDC, DOH, CLPPP and its advisory council, supporting the screening of children in at-risk groups. The document includes the Florida Agency for Health Care Administration requirement that all Medicaid eligible children receive a blood-lead test at age 12 months, age 24 months or between the ages of 36 and 72 months. The Screening Guideline provides a case management structure of services and interventions which were updated in 2003 to meet the most current CDC recommendations. County CLPPPs collaborate with local partners to identify and ensure that children in high-risk groups are screened. They also assist private providers and the DOH's Children's Medical Service Program, to provide care and treatment of children with elevated blood levels.

Effect of Bill

HB 393 creates the "Lead Poisoning Prevention Screening and Education Act." The bill asserts the Department of Health's role as the entity responsible for public health education, and expands DOH's health education responsibilities by establishing a program designed to increase public awareness on the hazards of lead-based paint poisoning. The bill also creates a collaborative public information initiative along with the Governor, the Secretary of Health, and private industry representatives to provide public service announcements and to develop and distribute culturally and linguistically appropriate information.

The bill establishes a state-wide screening program for early identification of lead poisoning. The program provides screening for children under 6 years of age. Other than children, persons at risk are given priority for screening. The bill establishes guidelines for medical follow-up of children identified with elevated lead blood levels. The bill also requires the Department of Health to disclose cases or probably cases of lead poisoning to the affected individual, his or her parent or legal guardian if the individual is a minor, and to the secretary of the Department of Health. The secretary is required to maintain comprehensive records of all screenings conducted.

C. SECTION DIRECTORY:

Section 1. Creates an unnamed section to provide a popular name.

Section 2. Provides legislative findings related to lead poisoning.

Section 3. Creates definitions.

Section 4. Establishes the Lead Poisoning Prevention Educational Program; establishes a public information initiative; establishes distribution of literature about childhood lead poisoning.

Section 5. Establishes a lead screening program.

Section 6. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None

2. Expenditures:

Estimated Expenditures	1st Year	2nd Year (Annualized/Recurring)
Salaries		
3 Environmental Specialist I @$45,222 (1 Epidemiologist, 1 Screening Program Coordinator, and 1 Evaluation Specialist)	$ 177,722	$ 183,054
1 Data Manager@$36,000	47,160	48,575
1 Admin Support Specialist @$21,830	28,597	29,455
1 Outreach Coordinator @$42,000	55,020	56,571
(FTE computed w/31% fringe)		
Other Personal Services	- 0 -	- 0 -
Expense		
4 FTE @ Std DOH Professional package w/limited travel @$13,733 and 2 FTE @ Std DOH support staff @ $7,986 first year	$ 70,904	$ 51,950
Screening costs @$20/screening	300,000	309,000
Case management of 63 cases	30,240	32,000
Educational materials	50,000	52,000
Screening database development	25,000	15,000
Operating Capital Outlay		
4 FTE @ Std. DOH Professional package @ $1,900 and 2 FTE support staff @ $2,100	11,800	
HR Service FTE 4 @$393	2,358	2,358
Total Estimated Expenditures	$ 798,802	$ 780,063

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private industry organizations, including those involved in real estate, insurance mortgage banking and pediatrics would be solicited by the Department of Health in developing and coordinating a state-wide public information initiative regarding the "Lead Poisoning Prevention Screening and Prevention act." Health care providers and child care facility owners or operators would be responsible to distribute information pamphlets regarding childhood lead poisoning, testing, prevention and treatment.

D. FISCAL COMMENTS:

The lead poisoning prevention program is funded through a grant from the Center for Disease Control (CDC). The department will apply for grant funds (as in prior years) to continue the program for the 2006/07 fiscal year. The department's estimated cost to implement the bill is $798,802 as outlined above reflects certain DOH staff and operational expenses. Of this, CDC grant monies are anticipated

to fund $322,536, leaving a deficit cost (according to the department) to implement the aspects of the bill of $476,286.

For the 2006/07 fiscal year, $308,000 in recurring general revenue funds is appropriated to the Department of Health for the purposes of this act. Such an appropriation is contingent upon the Department of Health receiving a federal lead poisoning prevention grant of $1 million or greater.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None

B. RULE-MAKING AUTHORITY:

The Department of Health is provided the rulemaking authority to implement this act. Specifically, the bill would require the Secretary of Health to codify the current Childhood Lead Poisoning Screening Guidelines and medical follow-up guidelines.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to the Lead Poisoning Prevention Screening and Education Act; providing a short title; providing legislative findings; providing definitions; providing for the establishment of a statewide comprehensive educational program on lead poisoning prevention; providing for a public information initiative; providing for distribution of literature about childhood lead poisoning; requiring the establishment of a screening program for early identification of persons at risk of elevated levels of lead in the blood; providing for screening of children; providing for prioritization of screening; providing for the maintenance of records of screenings; providing for reporting of cases of lead poisoning; providing an appropriation; providing contingencies for appropriation; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Short title.--This act may be cited as the "Lead Poisoning Prevention Screening and Education Act."

Section 2. Legislative findings.--

(1) Nearly 300,000 American children may have levels of lead in their blood in excess of 10 micrograms per deciliter (ug/dL). Unless prevented or treated, elevated blood-lead levels in egregious cases may result in impairment of the ability to think, concentrate, and learn.

(2) A significant cause of lead poisoning in children is

the ingestion of lead particles from deteriorating lead-based paint in older, poorly maintained residences.

(3) Childhood lead poisoning can be prevented if parents, property-owners, health professionals, and those who work with young children are informed about the risks of childhood lead poisoning and how to prevent it.

(4) Knowledge of lead-based-paint hazards, their control, mitigation, abatement, and risk avoidance is not sufficiently widespread.

(5) Most children who live in older homes and who otherwise may be at risk for childhood lead poisoning are not tested for the presence of elevated lead levels in their blood.

(6) Testing for elevated lead levels in the blood can lead to the mitigation or prevention of the harmful effects of childhood lead poisoning and may also prevent similar injuries to other children living in the same household.

Section 3. Definitions.--As used in this act, the term:

(1) "Affected property" means a room or group of rooms within a property constructed before January 1, 1960, or within a property constructed between January 1, 1960, and January 1, 1978, where the owner has actual knowledge of the presence of lead-based paint, that form a single independent habitable dwelling unit for occupation by one or more individuals and that has living facilities with permanent provisions for living, sleeping, eating, cooking, and sanitation. Affected property does not include:

(a) An area not used for living, sleeping, eating, cooking, or sanitation, such as an unfinished basement;

(b) A unit within a hotel, motel, or similar seasonal or transient facility, unless such unit is occupied by one or more persons at risk for a period exceeding 30 days;

(c) An area that is secured and inaccessible to occupants; or

(d) A unit that is not offered for rent.

(2) "Dust-lead hazard" means surface dust in a residential dwelling or a facility occupied by a person at risk which contains a mass-per-area concentration of lead equal to or exceeding 40 ug/ft2 on floors or 250 ug/ft2 on interior windowsills based on wipe samples.

(3) "Elevated blood-lead level" means a quantity of lead in whole venous blood, expressed in micrograms per deciliter (ug/dL), which exceeds 10 ug/dL or such other level as specifically provided in this act.

(4) "Lead-based paint" means paint or other surface coatings that contain lead equal to or exceeding 1.0 milligram per square centimeter, 0.5 percent by weight, or 5,000 parts per million (ppm) by weight.

(5) "Lead-based-paint hazard" means paint-lead hazards and dust-lead hazards.

(6) "Owner" means a person, firm, corporation, nonprofit organization, partnership, government, guardian, conservator, receiver, trustee, executor, or other judicial officer, or other entity which, alone or with others, owns, holds, or controls the freehold or leasehold title or part of the title to property, with or without actually possessing it. The definition includes a vendee who possesses the title, but does not include a

mortgagee or an owner of a reversionary interest under a ground rent lease. The term includes any authorized agent of the owner, including a property manager or leasing agent.

(7) "Paint-lead hazard" means any one of the following:

(a) Any lead-based paint on a friction surface that is subject to abrasion and where the dust-lead levels on the nearest horizontal surface underneath the friction surface, such as the windowsill or floor, are equal to or greater than the dust-lead-hazard levels defined in subsection (2);

(b) Any damaged or otherwise deteriorated lead-based paint on an impact surface that is caused by impact from a related building material, such as a door knob that knocks into a wall or a door that knocks against its door frame;

(c) Any chewable lead-based painted surface on which there is evidence of teeth marks; or

(d) Any other deteriorated lead-based paint in or on the exterior of any residential building or any facility occupied by a person at risk.

(8) "Person at risk" means a child under the age of 6 years or a pregnant woman who resides or regularly spends at least 24 hours per week in an affected property.

(9) "Secretary" means the secretary of the Department of Health or a designee chosen by the secretary to administer the Lead Poisoning Prevention Screening and Education Act.

(10) "Tenant" means the individual named as the lessee in a lease, rental agreement, or occupancy agreement for a dwelling unit.

Section 4. Educational programs.--

(1) LEAD POISONING PREVENTION EDUCATIONAL PROGRAM ESTABLISHED.--In order to achieve the purposes of this act, a statewide, multifaceted, ongoing educational program designed to meet the needs of tenants, property owners, health care providers, early childhood educators, care providers, and realtors is established.

(2) PUBLIC INFORMATION INITIATIVE.--The Governor, in conjunction with the Secretary of Health and his or her designee, shall sponsor a series of public service announcements on radio, television, the Internet, and print media about the nature of lead-based-paint hazards, the importance of standards for lead poisoning prevention in properties, and the purposes and responsibilities set forth in this act. In developing and coordinating this public information initiative, the sponsors shall seek the participation and involvement of private industry organizations, including those involved in real estate, insurance, mortgage banking, and pediatrics.

(3) DISTRIBUTION OF LITERATURE ABOUT CHILDHOOD LEAD POISONING.--By January 1, 2007, the Secretary of Health or his or her designee shall develop culturally and linguistically appropriate information pamphlets regarding childhood lead poisoning, the importance of testing for elevated blood-lead levels, prevention of childhood lead poisoning, treatment of childhood lead poisoning, and, where appropriate, the requirements of this act. These information pamphlets shall be distributed to parents or the other legal guardians of children 6 years of age or younger on the following occasions:

(a) By a health care provider at the time of a child's

birth and at the time of any childhood immunization or vaccination unless it is established that such information pamphlet has been provided previously to the parent or legal guardian by the health care provider within the prior 12 months.

(b) By the owner or operator of any child care facility or preschool or kindergarten class on or before October 15 of the calendar year.

Section 5. Screening program.--

(1) The secretary shall establish a program for early identification of persons at risk of having elevated blood-lead levels. Such program shall systematically screen children under 6 years of age in the target populations identified in subsection (2) for the presence of elevated blood-lead levels. Children within the specified target populations shall be screened with a blood-lead test at age 12 months and age 24 months, or between the ages of 36 months and 72 months if they have not previously been screened. The secretary shall, after consultation with recognized professional medical groups and such other sources as the secretary deems appropriate, promulgate rules establishing:

(a) The means by which and the intervals at which such children under 6 years of age shall be screened for lead poisoning and elevated blood-lead levels.

(b) Guidelines for the medical followup on children found to have elevated blood-lead levels.

(2) In developing screening programs to identify persons at risk with elevated blood-lead levels, priority shall be given to persons within the following categories:

(a) All children enrolled in the Medicaid program at ages 12 months and 24 months, or between the ages of 36 months and 72 months if they have not previously been screened.

(b) Children under the age of 6 years exhibiting delayed cognitive development or other symptoms of childhood lead poisoning.

(c) Persons at risk residing in the same household, or recently residing in the same household, as another person at risk with a blood-lead level of 10 ug/dL or greater.

(d) Persons at risk residing, or who have recently resided, in buildings or geographical areas in which significant numbers of cases of lead poisoning or elevated blood-lead levels have recently been reported.

(e) Persons at risk residing, or who have recently resided, in an affected property contained in a building that during the preceding 3 years has been subject to enforcement for violations of lead-poisoning-prevention statutes, ordinances, rules, or regulations as specified by the secretary.

(f) Persons at risk residing, or who have recently resided, in a room or group of rooms contained in a building whose owner also owns a building containing affected properties which during the preceding 3 years has been subject to an enforcement action for a violation of lead-poisoning-prevention statutes, ordinances, rules, or regulations.

(g) Persons at risk residing in other buildings or geographical areas in which the secretary reasonably determines there to be a significant risk of affected individuals having a blood-lead level of 10 ug/dL or greater.

(3) The secretary shall maintain comprehensive records of all screenings conducted pursuant to this section. Such records shall be indexed geographically and by owner in order to determine the location of areas of relatively high incidence of lead poisoning and other elevated blood-lead levels.

All cases or probable cases of lead poisoning found in the course of screenings conducted pursuant to this section shall be reported to the affected individual, to his or her parent or legal guardian if he or she is a minor, and to the secretary.

Section 6. For the 2006-2007 fiscal year, $308,000 in recurring general revenue funds is appropriated to the Department of Health for the purpose of this act. For the 2006-2007 fiscal year, $1 million is appropriated to the Administrative Trust Fund in the Department of Health for the purpose of this act.

Section 7. Sections 4, 5, and 6 shall take effect only upon the Department of Health receiving federal lead-poisoning-prevention funds of $1 million or greater.

Section 8. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2006.

Workshop HB 89

A bill to be entitled

An act relating to emergency management; amending s. 252.355, F.S.; specifying additional agencies that are required to provide registration information to special needs clients and persons with disabilities or special needs who receive services from such agencies for purposes of inclusion within the registry of persons with special needs maintained by local emergency management agencies; providing that the Department of Community Affairs shall be the designated lead agency responsible for community education and outreach to the general public, including special needs clients, regarding registration as a person with special needs, special needs shelters, and general information regarding shelter stays; requiring the department to disseminate educational and outreach information through local emergency management offices; requiring the department to coordinate community education and outreach related to special needs shelters with specified agencies and entities; providing that specified confidential and exempt information relating to registration of persons with special needs be provided to the Department of Health; amending s. 381.0303, F.S.; providing for the operation, maintenance, and closure of special needs shelters; removing a condition of specified funding as a prerequisite to the assumption of lead responsibility by the Department of Health for specified coordination with respect to the development of a plan for the staffing and medical management of special needs

shelters; providing that the local Children's Medical Services offices shall assume lead responsibility for specified coordination with respect to the development of a plan for the staffing and medical management of pediatric special needs shelters; requiring such plans to conform to the local comprehensive emergency management plan; requiring county governments to assist in the process of coordinating the recruitment of health care practitioners to staff local special needs shelters; providing that the appropriate county health department, Children's Medical Services office, and local emergency management agency shall jointly determine the responsibility for medical supervision in a special needs shelter; providing that state employees with a preestablished role in disaster response may be called upon to serve in times of disaster in specified capacities; requiring the Secretary of Elderly Affairs to convene a multiagency emergency special needs shelter response team or teams to assist local areas that are severely impacted by a natural or manmade disaster that required the use of special needs shelters; providing duties and responsibilities of multiagency response teams; authorizing local emergency management agencies to request the assistance of a multiagency response team; providing for the inclusion of specified state agency representatives on each multiagency response team; authorizing hospitals and nursing homes that are used to shelter special needs persons during or after an

evacuation to submit invoices for reimbursement to the Department of Health; requiring the department to specify by rule expenses that are reimbursable and the rate of reimbursement for services; prescribing means of and procedures for reimbursement; providing eligibility for reimbursement of health care facilities to whom special needs shelter clients have been discharged by a multiagency response team upon closure of a special needs shelter; providing requirements with respect to such reimbursement; prescribing means of and procedures for reimbursement; disallowing specified reimbursements; revising the role of the special needs shelter interagency committee with respect to the planning and operation of special needs shelters; providing required functions of the committee; providing that the committee shall recommend guidelines to establish a statewide database to collect and disseminate special needs registration information; revising the composition of the special needs shelter interagency committee; requiring the inclusion of specified rules with respect to special needs shelters and specified minimum standards therefor; providing requirements with respect to emergency management plans submitted by a home health agency, nurse registry, or hospice to a county health department for review; removing a condition of specified funding as a prerequisite to the submission of such plans; amending s. 252.385, F.S.; requiring the Division of Emergency Management of the Department of Community Affairs to prepare and submit a

statewide emergency shelter plan to the Governor and the Cabinet for approval; providing plan requirements; requiring the Department of Health to assist the division in determining the estimated need for special needs shelter space; requiring inspection of public hurricane evacuation shelter facilities by local emergency management agencies prior to activation of such facilities; amending s. 400.492, F.S.; providing that nurse registries, hospices, and durable medical equipment providers shall prepare and maintain a comprehensive emergency management plan; providing that home health, hospice, and durable medical equipment provider agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services; authorizing home health agencies, nurse registries, hospices, and durable medical equipment providers to establish links to local emergency operations centers to determine a mechanism to approach areas within a disaster area in order for the agency to reach its clients; providing that the presentation of home care or hospice clients to the special needs shelter without the home health agency or hospice making a good faith effort to provide services in the shelter setting constitutes abandonment of the client; requiring regulatory review in such cases; amending s. 408.831, F.S.; providing that entities regulated or licensed by the Agency for Health Care Administration may exceed their licensed capacity to

act as a receiving facility under specified circumstances; providing requirements while such entities are in an overcapacity status; providing for issuance of an inactive license to such licensees under specified conditions; providing requirements and procedures with respect to the issuance and reactivation of an inactive license; providing fees; creating s. 252.357, F.S., requiring the Florida Comprehensive Emergency Management Plan to permit the Agency for Health Care Administration to initially contact nursing homes in disaster areas for specified monitoring purposes; requiring the agency to publish an emergency telephone number for use by nursing homes; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 252.355, Florida Statutes, is amended to read:

252.355 Registry of persons with special needs; notice.--

(1) In order to meet the special needs of <u>clients</u> ~~persons~~ who would need assistance during evacuations and sheltering because of physical, mental, <u>cognitive impairment,</u> or sensory disabilities, each local emergency management agency in the state shall maintain a registry of persons with special needs located within the jurisdiction of the local agency. The registration shall identify those persons in need of assistance and plan for resource allocation to meet those identified needs. To assist the local emergency management agency in identifying

such persons, the Department of Children and Family Services, Department of Health, Agency for Health Care Administration, Department of Education, Agency for Persons with Disabilities, ~~Department of Labor and Employment Security,~~ and Department of Elderly Affairs shall provide registration information to all of their special needs clients and to all people with disabilities or special needs who receive services ~~incoming clients as a part of the intake process~~. The registry shall be updated annually. The registration program shall give persons with special needs the option of preauthorizing emergency response personnel to enter their homes during search and rescue operations if necessary to assure their safety and welfare following disasters.

(2) The Department of Community Affairs shall be the designated lead agency responsible for community education and outreach to the general public, including special needs clients, regarding registration and special needs shelters and general information regarding shelter stays. The Department of Community Affairs shall disseminate such educational and outreach information through the local emergency management offices. The department shall coordinate the development of curriculum and dissemination of all community education and outreach related to special needs shelters with the Clearinghouse on Disability Information of the Governor's Working Group on the Americans with Disabilities Act, the Department of Children and Family Services, the Department of Health, the Agency for Health Care Administration, the Department of Education, the Agency for Persons with Disabilities, and the Department of Elderly

Affairs.

(3)~~(2)~~ On or before May 1 of each year each electric utility in the state shall annually notify residential customers in its service area of the availability of the registration program available through their local emergency management agency.

(4)~~(3)~~ All records, data, information, correspondence, and communications relating to the registration of persons with special needs as provided in subsection (1) are confidential and exempt from the provisions of s. 119.07(1), except that such information shall be available to other emergency response agencies, as determined by the local emergency management director, and shall be provided to the Department of Health in the furtherance of their duties and responsibilities.

(5)~~(4)~~ All appropriate agencies and community-based service providers, including home health care providers~~,~~ and hospices shall assist emergency management agencies by collecting registration information for persons with special needs as part of program intake processes, establishing programs to increase the awareness of the registration process, and educating clients about the procedures that may be necessary for their safety during disasters. Clients of state or federally funded service programs with physical, mental, cognitive impairment, or sensory disabilities who need assistance in evacuating, or when in shelters, must register as persons with special needs.

Section 2. Section 381.0303, Florida Statutes, is amended to read:

381.0303 ~~Health practitioner recruitment for~~ Special needs shelters.--

(1) PURPOSE.--The purpose of this section is to provide for the operation, maintenance, and closure of special needs shelters and to designate the Department of Health, through its county health departments, as the lead agency for coordination of the recruitment of health care practitioners, as defined in s. 456.001(4), to staff special needs shelters in times of emergency or disaster and to provide resources to the department to carry out this responsibility. However, nothing in this section prohibits a county health department from entering into an agreement with a local emergency management agency to assume the lead responsibility for recruiting health care practitioners.

(2) SPECIAL NEEDS SHELTER PLAN; STAFFING; CLOSURE; STATE AGENCY ASSISTANCE ~~AND STAFFING~~.--~~Provided funds have been appropriated to support medical services disaster coordinator positions in county health departments,~~

(a) The department shall assume lead responsibility for the ~~local~~ coordination of local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of special needs shelters. The local Children's Medical Services offices shall assume lead responsibility for the local coordination of local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of pediatric special needs shelters. Plans shall conform to ~~The plan shall be~~

~~in conformance with~~ the local comprehensive emergency management plan.

(b) ~~(a)~~ County health departments shall, in conjunction with the local emergency management agencies, have the lead responsibility for coordination of the recruitment of health care practitioners to staff local special needs shelters. County health departments shall assign their employees to work in special needs shelters when those employees are needed to protect the health and safety of special needs clients ~~of patients~~. County governments shall assist in this process.

(c) ~~(b)~~ The appropriate county health department, Children's Medical Services office, and local emergency management agency shall jointly decide ~~determine~~ who has responsibility for medical supervision in each ~~a~~ special needs shelter and shall notify the department of their decision.

(d) ~~(c)~~ Local emergency management agencies shall be responsible for the designation and operation of special needs shelters during times of emergency or disaster and the closure of the facilities following an emergency or disaster. County health departments shall assist the local emergency management agency with regard to the management of medical services in special needs shelters.

(e) State employees with a preestablished role in disaster response may be called upon to serve in times of disaster commensurate with their knowledge, skills, and abilities and any needed activities related to the situation.

(f) The Secretary of Elderly Affairs, or his or her designee, shall convene, at any time that he or she deems

appropriate and necessary, a multiagency emergency special needs shelter response team or teams to assist local areas that are severely impacted by a natural or manmade disaster that requires the use of special needs shelters. Multiagency response teams shall provide assistance to local emergency management agencies with the continued operation or closure of the shelters, as well as with the discharge of special needs clients to alternate facilities if necessary. Local emergency management agencies may request the assistance of a multiagency response team by alerting statewide emergency management officials of the necessity for additional assistance in their area. The Secretary of Elderly Affairs is encouraged to proactively work with other state agencies prior to any natural disasters for which warnings are provided to ensure that multiagency response teams are ready to assemble and deploy rapidly upon a determination by state emergency management officials that a disaster area requires additional assistance. The Secretary of Elderly Affairs may call upon any state agency or office to provide staff to assist a multiagency response team or teams. Unless the secretary determines that the nature or circumstances surrounding the disaster do not warrant participation from a particular agency's staff, each multiagency response team shall include at least one representative from each of the following state agencies:

1. Department of Elderly Affairs.
2. Department of Health.
3. Department of Children and Family Services.
4. Department of Veterans' Affairs.
5. Department of Community Affairs.

6. Agency for Health Care Administration.

7. Agency for Persons with Disabilities.

(3) REIMBURSEMENT TO HEALTH CARE PRACTITIONERS AND FACILITIES.--

(a) The Department of Health shall upon request reimburse~~,~~ ~~subject to the availability of funds for this purpose,~~ health care practitioners, as defined in s. 456.001, provided the practitioner is not providing care to a patient under an existing contract, and emergency medical technicians and paramedics licensed under ~~pursuant to~~ chapter 401, for medical care provided at the request of the department in special needs shelters or at other locations during times of emergency or a declared ~~major~~ disaster. Reimbursement for health care practitioners, except for physicians licensed under ~~pursuant to~~ chapter 458 or chapter 459, shall be based on the average hourly rate that such practitioners were paid according to the most recent survey of Florida hospitals conducted by the Florida Hospital Association. Reimbursement shall be requested on forms prepared by the Department of Health and shall be paid as specified in paragraph (d).

(b) Hospitals and nursing homes that are used to shelter special needs clients during or after an evacuation may submit invoices for reimbursement to the department. The department shall develop a form for reimbursement and shall specify by rule which expenses are reimbursable and the rate of reimbursement for each service. Reimbursement for the services described in this paragraph shall be paid as specified in paragraph (d).

(c) If, upon closure of a special needs shelter, a

multiagency response team determines that it is necessary to discharge special needs shelter clients to other health care facilities, such as nursing homes, assisted living facilities, and community residential group homes, the receiving facilities shall be eligible for reimbursement for services provided to the clients for up to 90 days. Any facility eligible for reimbursement under this paragraph shall submit invoices for reimbursement on forms developed by the department. A facility must show proof of a written request from a representative of an agency serving on the multiagency response team that the client for whom the facility is seeking reimbursement for services rendered was referred to that facility from a special needs shelter. Reimbursement for the services described in this paragraph shall be paid as specified in paragraph (d).

(d) If a Presidential Disaster Declaration has been issued ~~made~~, and the Federal Government makes funds available, the department shall use those ~~such~~ funds for reimbursement of eligible expenditures. In other situations, or if federal funds do not fully compensate the department for reimbursements permissible under ~~reimbursement made pursuant to~~ this section, the department shall process a budget amendment to obtain reimbursement from unobligated, unappropriated moneys in the General Revenue Fund. The department shall not provide reimbursement to facilities under this subsection for services provided to a special needs client if, during the period of time in which the services were provided, the client was enrolled in another state-funded program, such as Medicaid or another similar program, which would otherwise pay for the same

services. Travel expense and per diem costs shall be reimbursed pursuant to s. 112.061.

(4) HEALTH CARE PRACTITIONER REGISTRY.--The department may use the registries established in ss. 401.273 and 456.38 when health care practitioners are needed to staff special needs shelters or to staff disaster medical assistance teams.

(5) SPECIAL NEEDS SHELTER INTERAGENCY COMMITTEE.--The Secretary ~~Department~~ of Health may establish a special needs shelter interagency committee and serve as or appoint a designee to serve as the committee's chair. The department shall provide any necessary staff and resources to support the committee in the performance of its duties~~, to be chaired and staffed by the department~~. The committee shall resolve problems related to special needs shelters not addressed in the state comprehensive emergency medical plan and shall consult on ~~serve as an oversight committee to monitor~~ the planning and operation of special needs shelters.

(a) The committee shall ~~may~~:

1. Develop and negotiate any necessary interagency agreements.

2. Undertake other such activities as the department deems necessary to facilitate the implementation of this section.

3. Submit recommendations to the Legislature as necessary. Such recommendations shall include, but not be limited to, the following:

a. Defining "special needs shelter."

b. Defining "special needs client."

c. Development of a uniform registration form for special

needs clients.

d. Improving public awareness regarding the registration process.

e. Improving overall communications with special needs clients both before and after a disaster.

f. Recommending the construction or designation of additional special needs shelters in underserved areas of the state and the necessity of upgrading, modifying, or retrofitting existing special needs shelters.

g. Recommending guidelines to establish a statewide database designed to collect and disseminate timely and appropriate special needs registration information.

(b) The special needs shelter interagency committee shall be composed of representatives of emergency management, health, medical, and social services organizations. Membership shall include, but shall not be limited to, representatives of the Departments of Health, Community Affairs, Children and Family Services, Elderly Affairs, ~~Labor and Employment Security,~~ and Education; the Agency for Health Care Administration; the Florida Medical Association; the Florida Osteopathic Medical Association; Associated Home Health Industries of Florida, Inc.; the Florida Nurses Association; the Florida Health Care Association; the Florida Assisted Living Affiliation ~~Association~~; the Florida Hospital Association; the Florida Statutory Teaching Hospital Council; the Florida Association of Homes for the Aging; the Florida Emergency Preparedness Association; the American Red Cross; Florida Hospices and Palliative Care, Inc.; the Association of Community Hospitals

and Health Systems; the Florida Association of Health Maintenance Organizations; the Florida League of Health Systems; Private Care Association; ~~and~~ the Salvation Army; the Florida Association of Aging Services Providers; and the AARP.

(c) Meetings of the committee shall be held in Tallahassee, and members of the committee shall serve at the expense of the agencies or organizations they represent. The committee shall make every effort to use teleconference or video conference capabilities in order to ensure statewide input and participation.

(6) RULES.--The department has the authority to adopt rules necessary to implement this section. Rules shall ~~may~~ include a definition of a special needs client ~~patient~~, ~~specify~~ physician reimbursement, and the designation of ~~designate which~~ county health departments which will have responsibility for the implementation of subsections (2) and (3). Standards for special needs shelters adopted by rule shall include minimum standards relating to:

(a) Staffing levels for provision of services to assist individuals with activities of daily living.

(b) Provision of transportation services.

(c) Compliance with applicable service animal laws.

(d) Eligibility criteria that includes individuals with physical, cognitive, and psychiatric disabilities.

(e) Provision of support and services for individuals with physical, cognitive, and psychiatric disabilities.

(f) Standardized applications that include specific eligibility criteria and the services an individual with special needs can expect to receive.

(g) Procedures for addressing the needs of unregistered individuals in need of shelter.

(h) Requirements that the special needs shelter location meets the Florida Accessibility Code for Building Construction. If the location fails to meet the standards, a plan must be provided describing how compliance will be achieved.

(i) Procedures for addressing the needs of families that are eligible for special needs shelter services. Specific procedures shall be developed to address the needs of families with multiple dependents where only one dependent is eligible for the special needs shelter. Specific procedures shall be developed to address the needs of adults with special needs who are caregivers for individuals without special needs.

(j) Standards for special needs shelters, including staffing, onsite emergency power, transportation services, supplies, including durable medical equipment, and any other recommendations for minimum standards as determined by the committee.

(7) ~~REVIEW OF~~ EMERGENCY MANAGEMENT PLANS; CONTINUITY OF CARE.--Each emergency management plan submitted to a county health department by a home health agency pursuant to s. 400.497, by a nurse registry pursuant to s. 400.506, or by a hospice pursuant to s. 400.610, shall specify the organization's functional staffing plan for special needs shelters to ensure continuity of care and services to its clients during and after

the disaster or emergency situation. ~~The submission of Emergency management plans to county health departments by home health agencies pursuant to s. 400.497(8)(c) and (d) and by nurse registries pursuant to s. 400.506(16)(e) and by hospice programs pursuant to s. 400.610(1)(b) is conditional upon the receipt of an appropriation by the department to establish medical services disaster coordinator positions in county health departments unless the secretary of the department and a local county commission jointly determine to require such plans to be submitted based on a determination that there is a special need to protect public health in the local area during an emergency.~~

Section 3. Subsections (2) and (4) of section 252.385, Florida Statutes, are amended to read:

252.385 Public shelter space.--

(2)(a) The division shall administer a program to survey existing schools, universities, community colleges, and other state-owned, municipally owned, and county-owned public buildings and any private facility that the owner, in writing, agrees to provide for use as a public hurricane evacuation shelter to identify those that are appropriately designed and located to serve as such shelters. The owners of the facilities must be given the opportunity to participate in the surveys. The Board of Regents, district school boards, community college boards of trustees, and the Department of Education are responsible for coordinating and implementing the survey of public schools, universities, and community colleges with the division or the local emergency management agency.

(b) By January 31 of each even-numbered year, the Division

of Emergency Management of the Department of Community Affairs shall prepare and submit a statewide emergency shelter plan to the Governor and the Cabinet for approval, subject to the requirements for approval provided in s. 1013.37(2). The plan must also identify the general location and square footage of special needs shelters, by regional planning council region, during the next 5 years. The Department of Health shall assist the division in determining the estimated need for special needs shelter space based on information from the special needs registration database and other factors.

(4)(a) Public facilities, including schools, postsecondary education facilities, and other facilities owned or leased by the state or local governments, but excluding hospitals or nursing homes, which are suitable for use as public hurricane evacuation shelters shall be made available at the request of the local emergency management agencies. The local emergency management agency shall inspect a designated facility to determine its readiness prior to activating such facility for a specific hurricane or disaster. Such agencies shall coordinate with the appropriate school board, university, community college, or local governing board when requesting the use of such facilities as public hurricane evacuation shelters.

(b) The Department of Management Services shall incorporate provisions for the use of suitable leased public facilities as public hurricane evacuation shelters into lease agreements for state agencies. Suitable leased public facilities include leased public facilities that are solely occupied by state agencies and have at least 2,000 square feet of net floor

area in a single room or in a combination of rooms having a minimum of 400 square feet in each room. The net square footage of floor area must be determined by subtracting from the gross square footage the square footage of spaces such as mechanical and electrical rooms, storage rooms, open corridors, restrooms, kitchens, science or computer laboratories, shop or mechanical areas, administrative offices, records vaults, and crawl spaces.

(c) The Department of Management Services shall, in consultation with local and state emergency management agencies, assess Department of Management Services facilities to identify the extent to which each facility has public hurricane evacuation shelter space. The Department of Management Services shall submit proposed facility retrofit projects that incorporate hurricane protection enhancements to the department for assessment and inclusion in the annual report prepared in accordance with subsection (3).

Section 4. Section 400.492, Florida Statutes, is amended to read:

400.492 Provision of services during an emergency.--Each home health agency, nurse registry, hospice, or durable medical equipment provider shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health, nurse registry, hospice, or durable medical equipment services during an emergency that interrupts patient care or services in the patient's home. The plan shall describe how the home health

agency, nurse registry, hospice, or durable medical equipment provider establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; providing for communication between staff members, county health departments, and local emergency management agencies, including a backup system; identifying resources necessary to continue essential care or services or referrals to other organizations subject to written agreement; and prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be continued in the event of an emergency or disaster for each patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving

skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health, hospice, and durable medical equipment provider agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records. Home health agencies, nurse registries, hospices, and durable medical equipment providers may establish links to local emergency operations centers to determine a mechanism to approach areas within the disaster area in order for the agency to reach its clients. The presentation of home care or hospice clients to a special needs shelter without the home health agency or hospice making a good faith effort to provide services in the shelter setting will constitute abandonment of the client and will result in regulatory review.

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county.

Section 5. Section 408.831, Florida Statutes, is amended to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.--

(1) In addition to any other remedies provided by law, the

agency may deny each application or suspend or revoke each license, registration, or certificate of entities regulated or licensed by it:

(a) If the applicant, licensee, registrant, or certificateholder, or, in the case of a corporation, partnership, or other business entity, if any officer, director, agent, or managing employee of that business entity or any affiliated person, partner, or shareholder having an ownership interest equal to 5 percent or greater in that business entity, has failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless a repayment plan is approved by the agency; or

(b) For failure to comply with any repayment plan.

(2) In reviewing any application requesting a change of ownership or change of the licensee, registrant, or certificateholder, the transferor shall, prior to agency approval of the change, repay or make arrangements to repay any amounts owed to the agency. Should the transferor fail to repay or make arrangements to repay the amounts owed to the agency, the issuance of a license, registration, or certificate to the transferee shall be delayed until repayment or until arrangements for repayment are made.

(3) Entities subject to this section may exceed their licensed capacity to act as a receiving facility in accordance with an emergency operations plan for clients of evacuating providers from a geographic area where an evacuation order has

been issued by a local authority having jurisdiction. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. Overcapacity status in excess of 15 days shall require compliance with all fire safety requirements or their equivalency as approved by state and local authorities, whichever is applicable. In addition, the agency shall approve requests for overcapacity beyond 15 days, which approvals shall be based upon satisfactory justification and need as provided by the receiving and sending facility.

(4) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area where a state of emergency was declared by the Governor of Florida if the provider:

(a) Suffered damage to the provider's operation during that state of emergency.

(b) Is currently licensed.

(c) Does not have a provisional license.

(d) Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.

An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 6 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license which states the beginning and ending

dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the licensee expiration date and all licensure fees must be current, paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.

(5)~~(3)~~ This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 381, 383, 390, 391, 393, 394, 395, 400, 408, 468, 483, and 641 or rules adopted pursuant to those chapters.

Section 6. Section 252.357, Florida Statutes, is created to read:

252.357 Monitoring of nursing homes during disaster.--The Florida Comprehensive Emergency Management Plan shall permit the Agency for Health Care Administration, working from the agency's offices or in the Emergency Operations Center, ESF-8, to make initial contact with each nursing home in the disaster area. The agency, by July 15, 2005, and annually thereafter, shall publish on the Internet an emergency telephone number that can be used

by nursing homes to contact the agency on a schedule established by the agency to report requests for assistance. The agency may also provide the telephone number to each facility when it makes the initial facility call.

Section 7. This act shall take effect July 1, 2006.

WILLIAM A. BELL

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CRISIS IN EMERGENCY CARE SERVICES

House Health Care General Committee
January 25, 2006

Bill Bell, General Counsel

Florida Hospital Association

Key Problems: Overcrowding and Shortage of Physicians/Nurses/Practitioners

Composition of ED Task Force

- Emergency physicians (FCEP)
- EMS
- Emergency nurses (FENA)
- Physician executives (FSHPE)
- FMA
- Hospital administration
- Healthcare attorneys (FAHA)
- Health plans
- AHCA
- DOH
- FHA

Increased Patient Volumes

- 17.9 million residents
- 80 million annual tourists
- Highest % elderly in country
- Seasonal residents
- Lack of community mental health services

Lack of Hospital Capacity

- Despite population growth and increases in hospital use,

  fewer hospital beds and EDs today than 10 years ago

Shortages of Physicians Taking ED On-Call Coverage

- Florida seeing slow growth in physician supply
- 1 in 4 physicians in Florida over 65 years of age
- AMA reports decline in growth in:
  - ✓general surgery
  - ✓surgical subspecialties
  - ✓radiology & pathology
- A significant shortage in the physician supply is predicted by 2020
- Some specialists such as plastic surgery, ENT, GI, ophthalmology, psychiatry and surgeons no longer need the hospital

FHA

Shortages of Nurses, EMS & Other Allied Health Personnel

Florida hospitals struggle to find:

- Nurses
- Pharmacists
- Radiology technologists
- Medical technologists
- Others

EMS is facing a significant shortage of:

- Paramedics
- EMTs

Medical Liability Concerns

- Physicians are concerned with increased risk of errors since they have no prior knowledge of the patient's history and they have little time to make life-saving diagnoses and treatment

Florida's Growing Uninsured Population

- 2.9 million residents without health insurance
- Rely on hospital EDs as their "safety net"
- Uninsured and insured patients, requiring after-hours care, use the ED for non-emergencies

Task Force Recommendations

Multi-faceted Approach

46 Recommendations

- Administrative Operations
- Regulatory – State/Federal
- Legislative
    - Data
    - Scope of Practice
    - Funding

Task Force Recommendations

- Develop data to identify gaps in the availability of specialties through the licensure process.
- Modify requirements for physicians wanting to volunteer their time to help the uninsured to permit a more expedited licensure process.

Task Force Recommendations

- Expand the Baker Act to allow private hospitals to be eligible for reimbursement from DCF.
- Develop transfer guidelines for crisis stabilization units to provide minimum mental and medical health screening exam.
- Permit EMS more flexibility in treating and transporting non-emergency patients.
- Increase state funding for uninsured, physician residency, nursing and mental health programs.

Florida College of
Emergency Physicians

Dr. David Siegel, MD, JD, FACEP, FACP
(Tampa, FL)

* President-Elect, Florida College of Emergency Physicians (FCEP)

* Member, FCEP Board of Directors since 2002

*Chair, American College of Emergency Physicians Membership Committee

* Member, FCEP Governmental Affairs, FCEP Medical Economics and FCEP Professional Development Committees

*Chair, National EMTALA Technical Advisory Group

*Past President of Pennsylvania ACEP Chapter

*Clinical Coordinator - Florida Medical Quality Assurance, Inc. (FMQAI)

*Associate Professor of Medicine, University of South Florida

Dr. Vidor Friedman, MD, FACEP
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*Member, FCEP Board of Directors since 2003

*Medical Director - Florida Hospital, Celebration

The State of Emergency Care in Florida

Presentation to the House Health Care General Committee

Wednesday, January 25th 2006

Florida College of Emergency Physicians

Presenters

- David M. Siegel, MD JD FACEP
  FCEP President-elect
  Tampa, Florida
- Vidor E. Friedman, MD FACEP
  FCEP Governmental Affairs Chair
  Orlando, Florida

About FCEP

- FCEP is the state chapter of the American College of Emergency Physicians, the oldest and largest emergency physician specialty society
- FCEP was founded in Florida in 1971
- There are approximately 1,100 members in Florida

Introduction

- Recent studies have highlighted the critical state of emergency care in Florida:
  - FHA Task Force Report: Addressing the Crisis in Emergency Care (December 2005)
  - Research conducted by USF and published in *Health Care Management Review* shows that nearly half of all care provided by emergency physicians goes uncompensated (December 2005)*
  - ACEP releases its "National Report Card on the State of Emergency Medicine" in January 2006, and Florida receives a grade of "C –"

*Orban, B. et al. "Uncompensated care provided by emergency physicians in Florida emergency departments." *Health Care Management Review* 2005. 30(4) 315-321.

USF Study on Uncompensated Care

- Emergency physicians are seeing ever higher numbers of uninsured patients
- A survey of 188 hospital emergency physician groups was conducted in 1998
- 83 groups responded that their uncompensated care rates range from 27% to 79%, with a statewide average of 47%
- This affects all patients, since the cost of providing uncompensated care is spread throughout the health care system.

ACEP National Report Card

- The emergency medicine system as a whole, nationwide, earned a grade of "C-"
- No state earned an "A" or an "F"
- Leading states, those with a "B", were California, Massachusetts, Connecticut and DC
- The worst states, those rating a "D+" or "D", were Alabama, Arizona, Arkansas, Idaho, Indiana, New Mexico, Oklahoma, South Dakota, Utah, Virginia, Washington and Wyoming
- More than 80 percent of states earned poor or near-failing overall grades ("C+" to "D")

Criteria of the Grade

- Overall state grades are an average of their grades in four categories:
  - Access to Emergency Care (availability of emergency care resources, public funding of health insurance, uninsured population, number of hospital staffed beds)
  - Quality and Patient Safety (state support for training of emergency physicians and EMS personnel, state commitment to measure ambulance diversion)

Criteria of the Grade

- Public Health and Injury Prevention (state support for health and safety programs, adoption and enforcement of safety belt and helmet laws, immunization rates and emergency preparedness)
- Medical Liability Environment (assessment of liability rates, caps on non-economic damages, availability of critical specialists)

Criteria of the Grade

- National task force developed evaluation criteria
- Criteria was divided into four categories, then each category was weighted for importance
  - Access 40%
  - Quality/Patient Safety 25%
  - Public Health/Injury Prevention 10%
  - Medical Liability 25%

Florida's Rank

- Overall, 30th out of 51
- Overall grade of "C-"
  - Access to Emergency Care "C-"
  - Quality and Patient Safety "B-"
  - Public Health/Injury Prevention "D-"
  - Medical Liability Environment "D"

Access to Emergency Care

- Florida does not have enough emergency facilities for its residents
  - Florida ranks near the bottom in number of ED's per 1 million people (47th) and in number of trauma centers per 1 million people (41st)
- Florida has a large percentage of the population that has no health insurance: 18.15%
- Florida only has 2.85 staffed hospital beds per 1,000 people
- Grade = "C-"

Quality and Patient Safety

- Florida ranks 12th in the number of EM residency programs and in its percentage of people with access to Enhanced 911 services
- USF in Tampa opened a new EM residency program in July 2003; more are hopefully on the way
- Training is offered statewide to hospital personnel for disaster response
  - Opportunity to further improve disaster training statewide via the Emergency Medicine Learning and Resource Center
- Grade = "B-"

Public Health and Injury Prevention

- Florida scores poorly in automobile safety
  - No primary seat belt enforcement
  - No helmet law for motorcyclists
  - 24.55 traffic fatalities per 100,000 licensed drivers
- Only 78% of children between 19-35 months are immunized
- Only 57% of adults over 65 received a flu shot
- No statewide intentional injury prevention programs for domestic violence, child abuse, intimate partner violence/sexual violence prevention and violence prevention for high-risk youth
- Grade = "D-"

Medical Liability Environment

- Florida recently adopted significant reforms for emergency care providers, including a $150,000 "hard cap" on non-economic damages for the provision of emergency care
- These reforms have not yet been tested in court
- Physicians have seen their medical liability rates increase 83.55% between 2001-2004
- Specialists have seen their medical liability rates increase 86.90% between 2001-2004
- Grade = "D"

Recommendations

- Work to increase the number of emergency departments and trauma centers
- Improve child immunization and older-adult flu vaccination programs
- Encourage the expansion of EM residency programs
- Adopt primary seat belt enforcement and motorcycle helmet laws
- Extend liability hard caps to all physicians, not just those providing emergency care

Questions?

Thank you!

Please visit us online at www.fcep.org

Uncompensated Care Provided by Emergency Physicians in Florida Emergency Departments

Barbara Langland-Orban
Etienne Pracht
Seena Salyani

Abstract: Uncompensated emergency department (ED) visits can negatively affect patients, clinicians, and hospitals, particularly as overcrowding occurs. Florida provides a unique market to analyze uncompensated ED care due to the high percent of for-profit hospitals, which typically provide significantly less uncompensated care, coupled with the older population that is more likely to be insured through Medicare.

A survey of 188 Florida hospital emergency physician groups was conducted to estimate the level of uncompensated care provided by each ED physician group in 1998. The response rate was 44 percent (eighty-three ED physician groups). All ED physician groups provided substantial uncompensated care regardless of hospital ownership type. Uncompensated care averaged 46.8 percent and ranged from 25.8 to 79.4 percent. A model was developed to predict the amount of uncompensated care using ED volume and payer mix. A rise in the percent of self-pay patients causes a disproportionate increase in uncompensated care, such that EDs with high levels of self-pay visits have markedly higher uncompensated care rates. The results suggest the need for a uniform reporting method of ED physician uncompensated care cost.

Key words: emergency department, emergency physician, uninsured

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Health Care Manage Rev, 2005, 30(4), 315-321

Uncompensated care (bad debt and charity care) is a growing dilemma for hospitals, physicians, and federal and state policy makers. It traditionally has been funded through cost shifting. However, health plans seeking lower prices make this strategy impractical. Public and private insurers have reduced the ability to absorb uncompensated care costs by decreasing their reimbursement rates.[1] Increased managed care penetration further reduces the ability to cost shift by reducing important funding sources.[2–4]

Uncompensated care is a particular challenge for hospital emergency departments (EDs) and emergency physicians. The 1986 Emergency Medical Treatment and Active Labor Act requires an ED medical screening exam regardless of a patient's willingness or ability to

pay or whether the medical complaint is an emergency. In addition, Medicaid managed care patients who do not receive care in a timely manner may seek ED services, which can further increase uncompensated care.[5] Uncompensated care also occurs when health plans deny payment for ED services or when patients do not pay assessed cost sharing fees.

The American Hospital Association reports that more than 1,100 EDs closed from 1988 to 1998. ED visits have increased annually since 1997 such that remaining EDs are averaging substantially more visits annually.[6] In 2000, Florida hospital EDs provided 1.5 million uncompensated ED visits.[7] Increased uncompensated visits can deter the consistent provision of timely and quality care since the visits do not generate funds for additional resources needed for the volume increase.

Volume and patient acuity increases have exhausted the capacity of many EDs. Overcrowding occurs when the need for outstrips available resources and can threaten access. It can be measured in many ways, such as excessive times waiting to be seen; delays in getting admitted ED patients to an inpatient bed; number of patients versus number of ED beds; required use of nontreatment areas (such as hallways) for providing care; patient acuity relative to staffing; and diverting incoming ambulance transports. Overcrowding places providers and patients at risk because it can lead to errors and poor outcomes.[8,9]

This study quantifies uncompensated care provided by Florida emergency physicians. Florida is a unique setting because the state has the highest percent of for-profit hospitals and the highest percent of Medicare beneficiaries, factors that are expected to be inversely associated with uncompensated care. The study used a survey of emergency physician groups at Florida hospitals regarding ED volume, payer mix, financial data, and uncompensated care to identify characteristics most prominently associated with uncompensated care.

SURVEY OF EMERGENCY PHYSICIAN GROUPS

SURVEY DESIGN

The survey was designed in consultation with the Florida College of Emergency Physicians (FCEP) to maximize the participation rate. FCEP advised that the survey should request secondary (existing) data to increase the response rate, and that the survey should be completed by the emergency physician group's billing office where the information typically resides.

The final survey requested information for 1998 on the total number of ED visits, number of visits by payer type (Medicare, Medicaid, commercial, self-pay, and other payer), total charges for ED physician services, disallowances, and uncompensated care charges. The University of South Florida Institutional Review Board approved the protocol and survey under the exempt category.

The survey requested information on charges, a proxy for costs, because costs are not readily available. A clear distinction exists between costs and charges. However, if similar markups are used for associated services, then the percentage change in charges should reflect the percentage change in costs. This will be true regardless of the mix of services.[10]

DATA COLLECTION

The AHA Guide was used to identify 194 Florida community hospitals with an ED and hospital ownership type and bed size.[11] FCEP staff provided contact information for billing persons and/or medical directors for each emergency physician group. Six ED groups were not surveyed because contact information for the ED physician group was not located.

Data were collected for the 1998 year. Accounts for 1998 should have been closed and collections completed when the survey began. The survey was sent in November 2000, and follow-up efforts continued through February 2002. The survey was sent by e-mail or fax depending on the information provided by FCEP. The initial request was sent to the billing contact person. If a billing contact was not identified, the survey was sent to the ED medical director. Contact persons were assured that all information would be confidential and reported only in aggregated statistics. A second request was made to nonrespondents. FCEP staff encouraged ED directors to participate during the initial and follow-up phases.

REVIEW OF SURVEY RESPONSES

Surveys were reviewed for consistency and accuracy. If information was inconsistent with defined assumptions, the contact person was requested to review and clarify or correct the information provided. A percent for each payer type was calculated by dividing the number of visits associated for the payer by the total ED visits. "Net charges" was defined as total gross charges less contractual allowances. Uncompensated care was defined as net charges less collections. Consistent with accounting principles, uncompensated care percent is defined as uncollected charges divided by adjusted (net) charges. As such, the numerator, uncompensated care charges, includes gross charges from self-pay patients and adjusted (net) charges from other payer

types. This value is referred to as "uncompensated care percent (net)."

While this is the correct accounting definition, it can overstate uncompensated care if a majority of uncompensated care is provided to self-pay patients. Self-pay charges are reported as gross charges because discounts are not applied and are considered in the context of net charges from most patients with rate discounts. Accordingly, an alternative rate for uncompensated care is provided, which calculates uncompensated care using gross charges. The "uncompensated care percent (gross)" rate uses the same numerator; however, the denominator is gross charges. This percentage underreports total uncompensated care because uncompensated care from patients with third party coverage and rate discounts is reported in the context of total gross charges.

DATA ANALYSIS

The analysis assesses the relationship between the uncompensated percent and hospital ownership, hospital size, and payer types. Simple *t* tests (with unequal variances) and analysis of variance (ANOVA) are used to compare mean percentages of uncompensated care based on ownership types and bed size. Pearson correlation coefficients are calculated to determine the direction and strength of the relationships between various payer types, uncompensated care, and ED volume. Finally, least squares multivariate regression is used to determine the relative influences of ED volume and payer type.

SURVEY RESULTS

The response rate was 44 percent (eighty-three respondents) from the 188 ED physician groups surveyed. Some respondents had very high uncompensated care rates, prompting a follow-up with the related billing contact person. Five respondents were excluded from the analysis because the response was for a partial year as the ED physician group assumed responsibility for the contract during the 1998 year or the data were not provided for the requested accounting cycle.

Twenty-seven respondents (33%) completed the survey as requested. The remainder comprised emergency physician billing firms that represented more than one hospital ED physician group. For these fifty-five respondents, the billing contact person was identified and a survey was completed for each individual hospital ED group. However, responses were not linked to a hospital name. Thirty surveys (36%) were submitted with a list of the associated hospitals. Thus, the hospital name is known, but not linked to a particular survey. Twenty-five responses (30%) did not identify the hospital by name and instead reported bed size and ownership type for each hospital ED group. ANOVA tests showed that the average uncompensated care percentage did not differ if the hospital was known or unknown.

SURVEY RESPONDENTS

Table 1 compares hospital characteristics of the seventy-eight survey respondents included in the analysis with characteristics of all Florida community hospitals. Florida has a high percent of for-profit hospitals relative to other states. In 1998, 15 percent of U.S. community hospitals were for-profit, compared with 46 percent in Florida.[12] Survey respondents were representative of Florida hospital ownership types and bed size categories.

A comparison is made between the payer mix of survey respondents with that of the nation's EDs.[13] Survey respondents exhibited a relatively high Medicare percent, consistent with Florida's elderly population. All other payer types were within one standard deviation of the national average.

UNCOMPENSATED CARE

The seventy-eight ED physician groups provided 1.85 million ED visits and more than $131 million in uncompensated care. Average emergency physician uncompensated care charges were $71.04 per visit. Table 2 provides descriptive statistics from the seventy-eight survey respondents.

Only fifty-two ED hospital physician groups were analyzed regarding ownership and size because hospital ownership type and bed size were not consistently

TABLE 1

Comparison of Hospital Characteristics of Survey Respondents with All Florida Community Hospitals

	Survey Respondents	All Florida Community Hospitals
Total number	78	204
Hospital ownership		
For-profit	50%	46%
Private not-for-profit	32%	44%
Public not-for-profit	18%	10%
Average hospital bed size	269	241
Bed size distribution		
<100 beds	14%	15%
100–199 beds	26%	24%
200–399 beds	45%	37%
>399 beds	15%	24%

TABLE 2

Descriptive Statistics for Respondents (n = 78)

	Mean	SD	Minimum	Maximum
Hospital bed size	269	215	42	1,376
Annual emergency visits	23,718	15,755	6,414	109,981
Payer mix (visits)				
Medicare percent	25.0%	9.5%	4.3%	49.4%
Medicaid percent	11.2%	5.7%	1.6%	27.8%
Private pay percent	32.3%	13.7%	8.2%	67.9%
Self-pay percent	21.7%	5.6%	8.5%	37.7%
Other payer percent	9.7%	10.2%	0.0%	49.6%
Financial (in thousands)				
Gross charges	$5,579	$4,158	$1,371	$29,016
Contractual allowances	$2,000	$1,430	$376	$6,860
Net charges	$3,579	$2,897	$956	$22,157
Collections	$1,975	$2,553	$443	$22,703
Uncompensated care charges	$1,685	$1,357	$338	$7,066
Uncompensated Care				
Uncompensated care percent (net)	46.8%	10.0%	25.8%	79.4%
Uncompensated care percent (gross)	30.1%	7.5%	14.4%	61.4%

linked to a specific hospital. Table 3 reports averages by type of hospital ownership. EDs in not-for-profit private and public hospitals tend to be larger (p = .018) with significantly more ED visits (p = .001). The mean uncompensated care percent (net) reported by all not-for-profit hospitals is not statistically different (p = .274) from that provided by for-profit hospitals.

This supports the hypothesis that the provision of charity care and community benefits depends more on a hospital's local market conditions than its ownership type.[14,15] Consequently, omitting hospital ownership from the multivariate analysis should not bias the results. To control for the influence of hospital size, the multivariate analysis includes ED volume as a measure of size. The correlation coefficient between hospital bed size and ED volume equals .804 (p = .001).

TABLE 3

Averages by Ownership Type n = 52

	Public NFP (n = 9)	Private NFP (n = 21)	For-Profit (n = 22)
Hospital bed size	452	281	194
ED visits	41,454	26,453	15,024
Payer mix			
Medicare percent	17.6%	23.3%	21.6%
Medicaid percent	12.5%	11.8%	14.6%
Private pay percent	30.9%	40.6%	40.9%
Self-pay percent	27.8%	21.1%	20.7%
Other payer percent	11.2%	3.1%	2.2%
Financial (in thousands)			
Gross charges	$10,405	$5,342	$3,015
Contractual allowances	$3,449	$1,780	$1,008
Net charges	$6,956	$3,562	$2,008
Collections	$4,438	$2,051	$1,016
Uncompensated care charges	$3,272	$1,487	$991
Uncompensated care percent (net)	51.6%	42.0%	48.0%
Uncompensated care percent (gross)	34.0%	28.3%	31.9%

PREDICTING UNCOMPENSATED CARE

Simple correlation coefficients were calculated for each payer type and uncompensated care percent (net). Self-pay percent, as expected, is the most highly correlated variable to uncompensated care percent (net), followed by Medicaid percent, with Pearson correlation coefficients of .728 (p = .001) and .459 (p = .001), respectively.

The influence of payer mix was further analyzed using multivariate regression. The dependent variable is uncompensated care percent (net). Because the payer type percentages may be systematically related, the data were tested for multicollinearity. No correlation coefficients larger than .80 among the independent variables was found. The largest coefficient is .72 and the R^2 of the whole model is .628, which indicates that multicollinearity is not a serious problem in the data. Further, the inclusion or exclusion of individual variables had

TABLE 4

Multivariate Regression Model Dependent Variable is Uncompensated Care Percent (net) (n = 78)

Variable	Coefficient (p value)
Intercept	.098* (.042)
ED volume	−.001* (.041)
Medicare percent	.146 (.112)
Medicaid percent	.596** (.001)
Self-pay percent	1.25** (.001)
Other payer percent	.196* (.016)
F value	24.3** (.001)
R^2	.628

*Estimate is significant at the α = .001 level.

**Estimate is significant at the α = .05 level.

minimal impact on the magnitude or significance of the remaining variables.

The results of the multivariate regression are reported in Table 4. The overall model is statistically significant (f value = 24.3, p = .001). Together the model variables explained 62.8 percent of the variation in the percent of uncompensated care (net).

Hospitals with 10,000 ED visits more than the average experience a one percentage point reduction in the percent of uncompensated care (net). The influence of the self-pay percent is greatest in magnitude. ED groups with a self-pay patient mix that is 10 percentage points higher than average experience a 12.5 percentage point increase in uncompensated care percent (net). Similarly, when the Medicaid or other payer percent is ten points higher than average, emergency physician groups are expected to experience a 6.0 and 2.0 percentage point increase in the uncompensated care percent (net), respectively. The Medicare percent variable does not have a statistically significant influence on uncompensated care percent, as compared with the private insurance control variable.

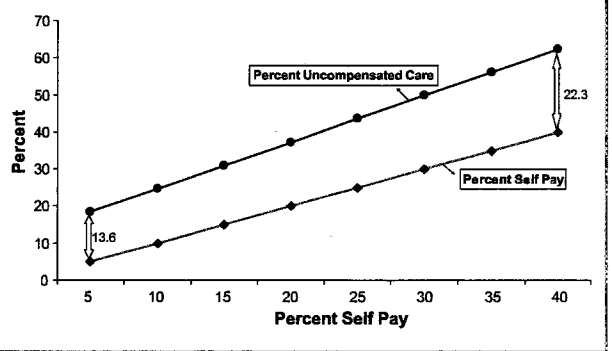
DISCUSSION

The proportion of Medicare patients did not affect the level of uncompensated care, such that the statistically higher percent of Medicare visits in Florida was not associated with increased or decreased uncompensated care levels. In addition, emergency physician uncompensated care was not a function of hospital ownership type as all ED physician groups provided significant amounts of uncompensated care. The influence of ownership may be marginal in EDs due to the major factors that influence ED uncompensated care. The self-pay and Medicaid populations provide proxies for the socioeconomic status of an ED patient population. The relatively low standard deviation of the self-pay and Medicaid patients reflects a tighter distribution around the mean, thereby suggesting the financial risk associated with these groups is more evenly distributed among EDs.

Previous research concludes that public hospitals and academic health centers serve a larger proportion of self-pay and Medicaid recipients than for-profit institutions with regard to all hospital services.[16] The very high levels of uncompensated care provided by some ED groups is consistent with research that nearly 75 percent of the patient population served by urban public hospitals was comprised of Medicaid beneficiaries and the uninsured.[2] While all emergency physician groups provide substantial levels of uncompensated care, large discrepancies exist at the physician group as well as the local market level. This is further evidenced in the estimated relationship between self-pay percent and uncompensated care percent (net), which indicates that the uncompensated care rate increases at a faster rate than the self-pay increase. Figure 1 illustrates the relatively disproportionate impact of an increasing percent of self-pay patients compared with other payers.

FIGURE 1

The Relationship Between the Percentage of Self-Pay Patients and the Expected Percentage of Uncompensated Care



The care provided by emergency physicians to the uninsured constitutes an extremely important source of medical care. However, these physicians have limited ability to cost shift to fund this care. More than 20 percent of visits were from Medicaid or the Other Payer variable, both of which are underfunded sources. Medicaid must be accepted as payment in full and patients cannot be billed for difference between Medicaid rates and charges. Medicaid's historically low reimbursement rates[16,17] substantially restricts the ability to shift costs from self-pay patients. The other payer variable, which was also associated with increased uncompensated care, includes numerous underfunded payer types such as worker's compensation, county or local health plans, and TriCare. Similar to Medicaid, the generally low reimbursement rates associated with these payers preclude cost shifting to fund uncompensated care costs.

Thus, an emergency physician group's ability to absorb uncompensated care costs while remaining financially viable is limited. More aggressive collections does not constitute a viable strategy for additional revenues when reimbursement rates are low or self-pay patients are unable to pay. Government programs have subsidized hospitals treating a disproportionate amount of poor patients (e.g., the disproportionate share hospital payment adjustment and Medicare's indirect medical education adjustment); however, these programs have not included physicians. Further, emergency physician groups do not have other business units or sources of revenue to subsidize high levels of uncompensated care costs. As such, high uncompensated care levels will result in continued consequences of ED overcrowding, which affects patients of all payer types.

The Centers for Medicare and Medicaid Services (CMS) announced $1 billion in funding to assist hospitals, emergency physicians, and ambulance providers with unpaid ED costs. Payments will be based on the costs incurred for initial emergency care and associated services.[18] This suggests the need to quantify and standardize reporting of emergency physician uncompensated care costs.

The importance of an intervention is underscored by the U.S. Census (2002),[19] which reports the number of uninsured persons increased since 1998. Emergency medicine physicians have advocated for fair reimbursement, tort reform due to the lack of affordable liability insurance, and recognition of uncompensated care as a practice expense.[20] Uncompensated care provided by hospital EDs and emergency physicians is substantial. Intervention by policy makers is indicated to reduce and deter uncompensated care to avoid the negative effects of ED overcrowding on hospitals, physicians, and patients and the closure of additional EDs. The results of this study provide some guidance concerning the structure for such a policy. Uniform reporting methods pertaining to uncompensated care, which include distinguishing between bad debt and charity care, are an essential component in identifying and quantifying problem areas and developing effective policy.

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